Brevard Chiropractic & Injury Center

Confidential Patient Health Record

Date	I.D. No

PERSONAL HISTORY

Name: _________________________________ Birth Date: ________Age:_____
Address: _______________________________ Sex: ___M___F
City: ___________________________State:________ Zip Code: ____________
Driver's License Number: ____
Social Security #:________________________
Home Phone: ___________________________
Work Phone: ____________________________
Cell Phone: _____________________________

Circle One: Married Single
Widowed Separated Divorced

Do you prefer calls at:
__Home __Work __Cell __Any

Employer: _______________________________
Type of Work: ____________________ Name of Spouse/Parent: ______________
Spouse/Parent's Social Security #:_______________________________________
Spouse/Parent's Employer: _________________ Type of Work________________
Spouse/Parent's Work Phone: _______________Cell:_______________________

IN CASE OF EMERGENCY, CONTACT:
Name: ______________________________ Relationship____________________
Home Phone: __________________ Work Phone: _________________________

_ _

Email Address: ____
**Your email will NOT be shared with any 3rd parties. For internal use only.*

How did you hear about us? (Circle All That Apply)
Brevardchiro.com - Brevarddisc.com - Facebook - Yellow Pages - Direct Mail
Drive By - TV - Radio - YouTube - Road Signs – Newspaper_________________
Internet Search Engine___________________ Other_________________________

Were you referred to our office? ___Yes ___No
If Yes, by whom? _______________________Phone Number_________________
Primary Care Physician: _______________________________
Physician's Phone Number: ____________________________

AGREEMENT WITH MEDICAL SERVICE PROVIDER

I, ________________________________, HEREBY, authorize my attorney to pay the proceeds of any net recovery all outstanding amounts owed to BREVARD CHIROPRACTIC & INJURY CENTER, for medical care or services. I agree that I am responsible to the above-named health care provider for the payment of all services rendered to me, regardless of the outcome of my case. My attorney is authorized to protect medical bills and expenses accrued. My attorney in no way accepts any direct or personal liability for any medical bills, expenses, or the payment of amounts owed to any health care provider. Any request by my attorney for any information or services are made on my behalf and are owed by me and in no way are the obligation of my attorney other than the withholding of suns from my recovery.

____ ________________

Patient Signature Date

____

Patient Printed Name

____

Treating Physician Signature

____

Treating Physician Printed Name

The undersigned attorney for the above patient agrees with the assignment and authorization. Any outstanding amounts, at the time of recovery, will be protected to the extent of the remaining recovery funds. No additional or excess amounts shall be protected or paid unless a separate written agreement is entered into. This protection agreement is valid only so long as the treating healthcare provider strictly complies with the terms above and withholds any collection efforts and does not report any adverse credit information on the above patient.

____ ________________

Attorney Signature Date

____

Attorney Printed Name

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3826 Murrell Road
Rockledge, Florida 32955
(321) 631-1100

ASSIGNMENT OF NO-FAULT INSURANCE BENEFITS

I hereby authorize, direct and demand that my personal injury protection insurance pay directly to my assignee **Brevard Chiropractic & Injury Center 3826 Murrell Road Rockledge, FL. 32955** such sums as my be due and owing in this Office for services rendered to me, both by reason of accident or illness and by reason of any other bills that are due this Office, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of all my rights, benefiting and privileges under my insurance policy to my assignees for any and all amounts owed.

I hereby assign and transfer to this my assignee/health care provider any and all causes of action that I may have or that might exist in my favor against my insurance company and authorize this Office to prosecute said cause of action either in my name or in the Office's name, and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize the Office to release pursuant to Privacy Rule, 45C.F.R. parts 160 and 164 promulgated pursuant to the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936 (1996), any information including, but not limited to, medical records, insurance information or documents otherwise pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment.

____ ____________________

Patient Signature Date

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3826 Murrell Road
Rockledge, FL. 32955
(321) 631-1100

Brevard Chiropractic & Injury Center

Confidential Patient Health Record

Date	I.D. No

PERSONAL HISTORY

Name:___________________________ Birth Date:_________Age:_____
Address:__________________________ Sex:___M___F
City:_______________State:_________ Driver's License Number:_____________
Zip Code:___________ Social Security #:___________________
Circle One: Married Single Widowed Separated Divorced
Home Phone:___________________
Cell Phone:______________________
Work Phone:_____________________
Do you prefer calls at __Home __Work __Cell __Any
Employer:______________________
Type of Work:___________________ Name of Spouse/Parent:_____________
Spouse/Parent's Social Security #:________________
Spouse/Parent's Employer:_________________ Type of Work________________
Spouse/Parent's Work Phone:_______________Cell:_______________

IN CASE OF EMERGENCY, CONTACT:
Name:_________________________ Relationship___________________
Home Phone:__________________ Work Phone:___________________

_ _

Email Address:___________________________________
*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements, promotions and registration on brevardchiro.com

How did you hear about us? (Circle All That Apply)
BCIC Website Myspace Yellow Pages Talking PhoneBook Billboard
Direct Mail Drive By TV Radio Magnet Road Signs
Newspaper___________ Internet Search Engine_______________
Other______________

Were you referred to our office?___Yes ___No
If Yes, By whom?____________________Phone Number_________________

Whom is your Primary Care Physician:______________________
Phone Number:__________________________

DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS

By way of original or a copy hereof, I ______________________________, the undersigned patient, hereby direct my applicable personal injury protection and/or medical payments insurance carrier to make payment directly to the undersigned medical provider for services and/or supplies rendered to me by said medical provider which were necessitated by a motor vehicle accident occurring on ____________________.

Additionally, I hereby authorize and direct my applicable personal injury protection and/or medical payments insurance carrier to make any and all checks or drafts payable to the undersigned medical provider only and to forward same to the undersigned medical provider's place of business.

This authorization for direct payment should not be deemed as assignment of benefits in that I, the patient, retain all rights to enforce my applicable insurance contact. Furthermore, this Direct Payment Authorization without Assignment of Benefits transfer no right, title, or interest in said contract other than the right to receive direct payment as specified hereinabove.

Prior authorizations for payment or assignments for PIP benefits to the undersigned medical provider, if any, are hereby cancelled and replaced by the Direct Payment Authorization without Assignment of Benefits as of the date shown above.

____ ____________________

Patient Signature Date

____ ____________________

Medical Provider Date

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3826 Murrell Road
Rockledge, FL. 32955
(321) 631-1100

Informed Consent to Chiropractic Adjustments and Care

I have been informed that it is not uncommon for patients to have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest it. If I am concerned about the discomfort or develop any new symptoms, I can call the office and speak to the staff. If I am out of town or unable to contact the doctor, I can present myself to the emergency room.

If any test were performed outside of this office (laboratory or other diagnostic procedures) I understand the doctor will notify me of the results at my next scheduled appointment or when the reports are available.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various methods of physical therapy and if necessary, diagnostic x-rays, on me by the doctor of chiropractic in this office and or anyone working in this clinic authorized by the doctor of chiropractic.

I further understand and have been informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to muscle strains and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based upon the facts then known, is in my best interests.

I have read the above consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

____________________________________ ____________________
Patient Date

____________________________________ ____________________
Parent or Guardian Date

____________________________________ ____________________
Witness Date

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3826 Murrell Road
Rockledge, FL. 32955
(321) 631-1100

INJURY HISTORY

Directions: *This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section that most closely applies to you.*

Section 1. Pain Intensity

□ I can tolerate the pain I have without using painkillers.
□ The pain is bad but I manage without taking painkiller
□ Painkillers give no relief from pain and I do not use them.
□ Painkillers give complete relief from pain.
□ Painkillers give moderate relief from pain.
□ Painkillers give very little relief from pain.

Section 2. Personal care (washing, dressing, etc.)

□ I can look after myself normally without causing extra pain.
□ I can look after myself normally but it causes extra pain.
□ It is painful to look after myself and I am slow and careful.
□ I need some help but manage most of my personal care.
□ I need help every day in most aspects of self-care.
□ I do not get dressed, wash with difficulty, and stay in bed.

Section 3. Lifting

□ I can lift heavy weights without extra pain.
□ I can lift heavy weights but it causes extra pain, but I can manage if they are conveniently positioned (on a table).
□ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
□ I can only life very light weights.
□ I cannot life or carry anything at all.

Section 4. Walking

□ Pain does not prevent me from walking any distance.
□ Pain prevents me from walking more than one mile.
□ Pain prevents me from walking more than ½ mile.
□ Pain prevents me from walking more than ¼ mile.
□ I can only walk using a cane or crutches.
□ I am in bed most of the time and have to crawl to the toilet.

Section 5. Sitting

□ I can sit in any chair as long as I like.
□ I can only sit in my favorite chair as long as I like.
□ Pain prevents me from sitting for more than one hour.
□ Pain prevents me from sitting for more than 30 minutes.
□ Pain prevents me from sitting for more than 10 minutes.
□ Pain prevents me from sitting at all.

Section 6. Standing
□ I can stand as long as I like without extra pain.
□ I can stand as long as I want but it causes extra pain.
□ Pain prevents me from standing for more than one hour.
□ Pain prevents me from standing for more than 30 minutes.
□ Pain prevents me from standing for more than 10 minutes.
□ Pain prevents me from standing at all.

Section 7. Sleeping
□ Pain does not prevent me from sleeping well.
□ I can sleep well only by using tablets.
□ Even when I take tablets I have less than 6 hours sleep.
□ Even when I take tablets I have less than 4 hours sleep.
□ Even when I take tablets I have less than 2 hours sleep.
□ Pain prevents me from sleeping at all.

Section 8. Sex Life
□ My sex life is normal and causes no extra pain.
□ My sex life is normal and causes some extra pain.
□ My sex life is nearly normal but is very painful.
□ My sex life is severely restricted by pain.
□ My sex life is nearly absent because of pain.
□ Pain prevents any sex life at all.

Section 9. Social Life
□ My social life is normal and gives me no extra pain.
□ My social life is normal but increase the degree of pain.
□ Pain has no significant effect on my social life apart from limiting my more energetic interests.
□ Pain has restricted my social life and I do not go out as often.
□ Pain has restricted my social life to my home.
□ I have no social life because of pain.

Section 10. Traveling
□ I can travel anywhere without extra pain.
□ I can travel anywhere but it gives me extra pain.
□ Pain is bad but I manage journeys over 2 hours.
□ Pain restricts me to journeys of less than one hour.
□ Pain restricts me to short necessary trips under a half hour.
□ Pain restricts me from traveling except to the doctor or hospital.

Brevard Chiropractic & Injury Center

Confidential Patient Health Record

Date	I.D.No

PATIENT INSURANCE INFORMATION

Who is responsible for this account?_____________________________________
Relationship to Patient:____

Primary Medical Insurance Company:___________________________________
Name and Date of Birth of Insured:_____________________________________
Phone Number of Insurance Company:___________________________________
Member ID #:____
Group #____

Secondary Medical Insurance Company:_________________________________
Name and Date of Birth of Insured:_____________________________________
Phone Number of Insurance Company:___________________________________
Member ID#:____
Group #:____

_ _

Reason for today's visit____
Is this condition due to an accident? __Yes __No Date of Accident:____________
Type of Accident __Auto __Work __Home __Other_______________
To whom have you made a report of your accident?
__Auto Insurance __Employer __Worker Compensation __Other
Do you have an attorney? __Yes __No If So, Name and Number___________________

Auto Insurance PIP Information
Name of Insurance Company:______________________________________
Name of Insured:____
Claim#:____
Name of Adjuster and Phone Number:_______________________________

_ _

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage with ___________________ and assign directly to Dr. Timothy Bortz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

__________________________________ __________________
Relationship Date

Notice of Privacy Practices

Brevard Chiropractic & Injury Center

Please review this notice carefully; this paperwork describes certain rights regarding how your Personal Health Information (PHI) may be used and disclosed, and how you can get access to your information.

Please contact our office manager/privacy official if you have any questions about this Notice of Privacy Practices.

This office may from time to time use and disclose your PHI in order to perform treatment, payment or healthcare operations, and for other purposes required by law. This Notice will explain your rights to access and amend your PHI and covers any individually identifiable health information about you relating to your past, present or future physical health care services.

This office is required by law to abide by the terms of this Notice of Privacy Practices. The notice may be changed from time to time, but we will inform you of any changes upon request.

1. **Uses and Disclosures of Personal Health Information (PHI).**

This office may, with or without your consent, use or disclose PHI for treatment, payment, or health care operations as set forth under HIPAA guidelines. There are, however, exceptions when certain uses and disclosures will require authorization from you.

This office may:
Use or disclose PHI to carry out treatment, payment or healthcare operations. Disclose PHI for treatment activities of another healthcare provider.

Disclose PHI to another covered entity or healthcare provider for payment activities of the entity that receives the information.

Disclose PHI to another covered entity for healthcare operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject for the PHI being requested if it is for a covered purpose or for the purpose of health care fraud and abuse, detection or compliance. We may disclose PHI about an individual to another covered entity that participates in an organization healthcare arrangement of which we are also a part.

Your Chiropractor, our office staff and others outside of our office who are involved in your health care treatment and services may use and disclose your PHI. Your PHI may also be used and disclosed to pay your healthcare bills and to support the operation of this practice.

The following are some of the ways we may use or disclose your PHI:

Treatment – We may use and disclose your PHI to provide health care and other service to you and to coordinate your care and services with third parties (for which we will obtain an authorization from you). We may also disclose PHI to other physicians who may be treating you or who may in the immediate future treat you. Additionally, we may disclose your PHI from time-to-time to another specialist or laboratory who, at our request, may provide your diagnosis or treatment to us to help in your treatment.

Payment – We may use or disclose your PHI to obtain payment for your health care services. This may include determining your eligibility of coverage for insurance benefits, reviewing necessary medical services, and undertaking utilization review activities for services you may need to receive.

Healthcare Operations – We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your Chiropractor is ready to see you. We may use or disclose your PHI to contact you to remind you of your appointment. All information used or disclosed by this office will be necessary for the purpose required. We may, but are not required to ask, you to sign a consent before we use or disclose your PHI.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object:

Public Health – We may disclose your PHI for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. The disclosures will be made for the purpose of controlling disease, injury or disability.

Abuse or Neglect – We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Legal Proceeding – We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal to the extent such disclosure is expressly authorized, in certain conditions in response to a subpoena.

Worker's Compensation – We may disclose your PHI as authorized to comply with worker's compensation laws and other similar legally-established programs.

Required Uses and Disclosures – Under the law, we must make disclosures to you and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164500 et. seq.

2. **YOUR RIGHTS**

This office abides by the rights given to you by the United States Government with regards to your PHI.

The following is an overview of your rights and how to exercise them:

You have the right to inspect and obtain a copy of your PHI – You may inspect and obtain a copy (for a minimum fee) of your PHI that is contained in a designated record set for as long as we maintain your PHI. A "designated record set" contains medical and billing records and any other records that we use for making decisions about your care.

You have the right to request a restriction or authorization of your PHI – You may ask us not to disclose all or any part of your PHI for the purpose of treatment, payment or health care operations. You may request that any part of your PHI not be disclosed to family members or friends who may be involved in your case or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. *We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If we do agree to the requested restriction, we will not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by doing so in writing and providing the detailed request to our Privacy Official.

You may also request that your PHI be released, in your absence, to the following individual(s):
please print name

_______________________________________ Relationship_______________________________

_______________________________________ Relationship_______________________________

_______________________________________ Relationship_______________________________

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. This request must be disclosed with our Privacy Official.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have the right to obtain a paper copy of this notice from us, upon request.

3. **Complaints**

You may direct your complaints to us or to the Secretary of Health and Human Services if you believe we have violated privacy rights. You may file a complaint with us by notifying our Privacy Official of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Official by phone at (321) 631-1100 for further information about the complaint process.

Office Policies and Privacy Statement

The nature of our practice is to give our patients the utmost in care and service. Please excuse delays. We will give you the same careful attention as soon as possible.

Our office is committed to providing you with the best *Chiropractic and Rehabilitative* service possible. Your chiropractic care is a form of rehabilitation and therefore will take place over time. For this reason you will be scheduled for a number of visits to be determined by your chiropractor after he or she has examined you.

It is important for you to follow the recommended care plan for best results. This includes frequency and duration of visits to help you achieve your maximum potential. Our goal is to provide a professional and beneficial experience to the patients to whom we render services. We look forward to helping you attain your personal goals and return to a normal, pain free life as soon as possible.

This office may, from time to time, use and disclose your Personal Health Information (PHI), in order to perform treatment, payment or health care operations, and for other purposes required by law. This notice is available for you to read and will explain your rights to access and emend your PHI and cover any individual identifiable health information about you relating to your past, present or future physical and mental health or conditions and related health care services.

We want to make your visits to Brevard Chiropractic & Injury Center as productive and pleasant as possible. Our office is very busy, while we are aware that unforeseen circumstances can sometimes occur, if for some reason you must cancel or reschedule an appointment, ***please call as soon as possible so that we can reschedule you.***

Repeated missed appointments will disrupt your progress. Our office is very busy, with a high demand for appointments; please give us as much notice as possible so that we may use your appointment space for someone else. ***Patients who show a repeated pattern of no-shows will be charged $20 for their missed appointments.***

As a courtesy to our patients we do file insurance claims for you to your primary insurance company. Our office staff will verify your insurance coverage and let you know your financial responsibility as soon as possible. Health insurance contracts are agreements between patients, their employers and the insurance company.

As a courtesy to our patients we will provide a copy of your medical records at a cost according to Florida Statutes and per written request. Additionally, should you or your insurance company require forms or information, this office reserves the right to charge for time spent in preparation of those forms or requested medical information.

It is your responsibility to make sure your insurance company is paying this office. Although this office may bill your insurance carrier for services rendered, all charges for services rendered are the patients' responsibility.

We will notify you as soon as we know of any difficulties we are having collecting monies from your insurance carrier. Should difficulties arise, you may need to contact your insurance company. If our office determines that your insurance carrier will reimburse you directly and not pay our office, you will be required to pay in full for all services at the time they are rendered. Our office makes every attempt to correspond with insurance carriers to assist them in correctly paying your claims.

All patients who have insurance, no matter the type it is, are required to pay co-payments, deductibles and/or percentages required each visit. If our office is a non-participating provider with the insurance company you have, we will gladly file those claims for you but you will be responsible for payment at the time service is rendered.

If you are a Medicaid enrollee, your eligibility status must be verified each month. If your eligibility is terminated, you become responsible for services rendered.

If you have been injured on the job, you must have authorization for care from the Worker's Compensation Insurance Company before an appointment or treatment can be rendered by our office. Your employer will assist you in securing that information.

X-RAY/MEDICAL RELEASE/INSURANCE INFORMATION:

I hereby authorize that all medical records, x-rays and any other pertinent medical information be released to Brevard Chiropractic & Injury Center. Also to disclose all insurance coverage for treatment provided herein.

______________________________________ ____________________

Patient Signature Social Security #

PAYMENT OF BILLS:

1. We will require you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you have made with us, please advise our financial department immediately so new arrangements can be made.
2. Any insurance checks sent to your home should be brought or sent to our office within three (3) days with Explanation of Benefits (stub/statement) to indicate which services were paid.

**Our office will submit your insurance claims for you as a courtesy. However, your insurance is an agreement between you and your carrier, not between your insurance company and this office.

Patients without insurance are expected to pay in full at the time services are rendered, unless other arrangements have been made with our financial department.

______________________________________ ____________________

Patient Signature Date

______________________________________ ____________________

Witness Date

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3826 Murrell Road
Rockledge, FL. 32955
(321) 631-1100

32. Have you missed time from work: □ Yes □ No
    If yes, full time off work:____________________ to ________________________
    If yes, part time off work:____________________ to ________________________
33. Did you seek medical help immediately after the crash? □ Yes □ No
34. If yes, how did you get there?□ Ambulance □ Police □ Someone else drove me
    □ Drove own car □ Other:______________________________________

35. Doctor # 1 name:____
    First visit date:___________________ Name of medical facility:_______________
    Location:______________________________
    Were you examined? □ Yes □ No
    Were X-rays taken? □ Yes □ No
    Did you receive treatment? □ Yes □ No
    If yes, what kind of treatment did you receive?____________________________
    Was this treatment helpful? □ Yes □ No
    Date of last treatment?____
36. Doctor # 2 name:____
    First visit date:___________________ Name of medical facility:_______________
    Location:______________________________
    Were you examined? □ Yes □ No
    Were X-rays taken? □ Yes □ No
    Did you receive treatment? □ Yes □ No
    If yes, what kind of treatment did you receive?____________________________
    Was this treatment helpful? □ Yes □ No
    Date of last treatment?____
37. Do you have an attorney on this claim? □ Yes □ No
    If yes, who?____
    Address:____
    Phone Number:____

Patient Consent, Authorization & Acknowledgment of Notice of Privacy Practices for Brevard Chiropractic & Injury Center

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures that may be required to fully evaluate my condition. I understand that I am under the care and supervision of the treating chiropractic physician and any treatment performed in this office and shall be by his or her order and under his or her supervision.

If the attending chiropractic physician is required to submit documentation, including patient histories, office notes or patient questionnaires to the contracted insurance company for review for medical payment, I authorize required information to be released.

I hereby attest that I have read the appropriate sections of the above document and fully understand all aspects of these office policies as they apply to myself and my method of payment for services rendered. I also attest that if I did not understand a section above, that I did ask for clarification from the office staff concerning the section in question.

I also attest that I have read the Notice of Privacy Practices for Brevard Chiropractic & Injury Center that was given to me and I understand that this Privacy statement is required by HIPAA, a governmental standard that all offices must now have.

____ ____________________

Patient Signature Date

____

Patient Printed Name

____ ____________________

Witness Date

Brevard Chiropractic & Injury Center
Timothy Bortz, D.C.
3826 Murrell Road
Rockledge, FL. 32955
(321) 631-1100

PERSONAL MEDICAL HISTORY

Name:_________________________________ Date:__________________

Past and Present Medical History:

Please check all that apply and describe.

Past	Present		
□	□	Tuberculosis	____________________
□	□	Mental Illness	____________________
□	□	Gout	____________________
□	□	Hypertension	____________________
□	□	Heart Attack	____________________
□	□	Kidney Disease	____________________
□	□	Epilepsy	____________________
□	□	Allergy	____________________
□	□	Cancer	____________________
□	□	Spinal Disorder	____________________
□	□	Diabetes	____________________
□	□	Arthritis	____________________
□	□	Migraines	____________________
□	□	Hepatitis	____________________
□	□	HIV/AIDS	____________________
□	□	Stroke	____________________
□	□	Pregnancy	____________________
□	□	Other:	____________________

Please check any of the following that apply and describe.

□ Major hospitalization or operations □ Past auto accidents
□ Past work accidents □ Major illnesses
Details:____

____

Previous Chiropractic Care: □ None □Doctor's Name and approximate date of last visit: ____

Do you suffer from any other condition other than the one you are consulting with us today? ____

List all prescription, over-the-counter medications and nutritional/herbal supplements you are taking. ____

____

Patient/Guardian Signature______________________________ Date_____________
Patient/Guardian Printed Name____

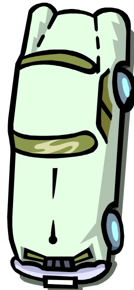
Brevard Chiropractic & Injury Center

Confidential Patient Health Record

Date	I.D.No

PERSONAL INJURY PATIENT HISTORY

1. Date of Accident:_____________________ 2. Time of Accident:________________________
3. Driver of car? □ ME ____
   How many people were in the car? □ 1 □ 2 □ 3 □ 4 □ More __________
4. Where were you seated? □ Mid front □ Left front □ Right front
   □ Left rear □ Mid rear □ Right rear
5. Who owns the car? □ ME ____
6. Year & Model of car you were in? _________________Transmission type: □ manual □ auto
   Year & Model of other car? _____________________ Transmission type: □manual □ auto
7. What was the approximate damage done to your car? $________________________________
8. Visibility at time of crash: □ Poor □ Fair □ Good □ Other __________________________
9. Road conditions at time of crash: □ Icy □ Wet □ Dry □ Other _______________________
   9a. Weather conditions: □ Clear □ Rainy □ Other ____________
   9b. Light conditions: □ Sunny/Bright □ Overcast/Cloudy □ Twilight □ Dark
   9c. Road Type: □ Concrete □ Asphalt □ Gravel □ Dirt □ Other _____________
10. Where was you car struck?



(draw an arrow)

I was traveling N S E W (circle one) on _______________________(name of road)
when:____
____
____
____

Illustrate below how the accident happened

11. Type of accident: □ Head-on collision □ Broadside collision □ Front impact
□ Rear-ended car in front □ Rear impact □ Non collision

12. At the time of the crash, recall what parts of your head or body struck what parts inside the car: ____

13. Did you see the crash coming? □ Yes □ No 14. Did you brace for impact? □ Yes □ No

15. Were seat belts worn? □ Yes □ No 16. Were shoulder harnesses worn? □ Yes □ No

17. Does your car have headrests? □ Yes □ No
If yes, what was the position of the headrests compared to your head before the crash?
□ Top of headrest even with bottom of head □ Top of headrest even with top of head
□ Top of headrest even with middle of neck

18. Is your car equipped with airbag(s)? □ Yes □ No Passenger air bag(s)? □ Yes □ No
Did airbag(s) deplore? □ Yes □ No If yes, were you struck? □ Yes □ No

19. Was you car braking? □ Yes □ No

20. Was your car moving at the time of the crash? □ Yes □ No
If yes, how fast would you estimate you were traveling: ____mph. □ Stopped

21. How fast would you estimate the other car was traveling: ____mph. □ Stopped

22. Head/Body position at the time of impact:
□ Head turned left/right □ Head looking back □ Head straight forward
□ Body straight in sitting position □ Body rotated right/left □ Other:________________

23. As a result of the crash you were: □ Rendered unconscious □ In shock
□ Dazed, circumstances vague □ Other: _____________________

24. How was the shoulder harness adjusted? □ Loose □ Snug

25. Were you wearing a hat or glasses? □ Yes □ No If yes, still on after crash? □ Yes □ No

26. Could you move all parts of your body? □ Yes □ No
If no, what parts couldn't you move and why?____________________________________
____

27. Were you able to get out of the car and walk unaided? □ Yes □ No
If no, why not?____

28. Did you get any bleeding cuts?□ Yes □ No If yes, where?___________________________

29. Did you get any bruises? □ Yes □ No If yes, where?_______________________________

30. Please describe how you felt:
Immediately after the crash:□ Dazed □ Confused □ Shaken □ Uncontrolled feelings □ Other
Later that day: □ Sore □ Stiff □ Little pain □ Moderate pain □ Severe pain
The next day: □ Better □ Same □ Worse □ Much worse □ Intolerable pain

31. Check the symptoms apparent since the crash (major symptoms listed below):

□ Headache	□ Neck pain/Stiffness	□ Mid back pain
□ Eyes light sensitive	□ Pain behind eyes	□ Dizziness
□ Fainting	□ Sleeping problems	□ Numbness in fingers
□ Numbness in toes	□ Fatigue	□ Loss of taste
□ Loss of memory	□ Loss of smell	□ Breath shortness
□ Irritability	□ Depression	□ Ringing/Buzzing
□ Loss of balance	□ Tension	□ Cold Hands
□ Cold feet	□ Diarrhea	□ Constipation
□ Chest pain	□ Nervousness	□ Cold sweats
□ Anxious	□ Facial pain	□ Clicking or popping jaw
□ Low back pain	□ Other:___________	